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O'Sullivan, Eoin, Pleace, Nicholas orcid.org/0000-0002-2133-2667, Busch-Geertsema, Volker et al. (1 more author) (2020) Distorting Tendencies in Understanding Homelessness in Europe. European Journal of Homelessness. pp. 109-135. ISSN 2030-3106

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Distorting Tendencies in Understanding Homelessness in Europe

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❯ **Abstract_** *In this paper, we summarise some of the recent developments within the social sciences in researching homelessness, in particular, the increasing use of longitudinal administrative and survey data, linking administrative and survey data, and the development of RCTS in evaluating interventions designed to assist those experiencing homelessness. Despite these methodological advances and innovations, cross-sectional research methods continue to be widely used, despite the long-standing identification of the limitations of this methodology for understanding homelessness, and this is particularly the case in medical research. We then explore some of the recent social science research on the links between the experience of homelessness and mental ill-health and substance misuse, which broadly concludes that the majority of people experiencing homelessness do not experience mental ill-health or substance misuse problems. We then provide case studies of medical research from Ireland, Germany, the UK, and Slovenia and argue that based on these case studies, such research continues to distort our understanding of homelessness and may inadvertently lead to ineffective policy responses that fail to resolve homelessness and demonstrate the limits of looking at the experience of homelessness in specific contexts and at specific times.*

❯ **Keywords_** *distorting tendencies in homelessness research, cross-section research, methodological innovations*

Introduction

In this contribution to the special edition on measuring homelessness in Europe, we focus our attention on the different methodologies that have been utilised to research those who are experiencing homelessness. In particular, we focus on how different methodological approaches and research traditions can generate divergent outcomes, for example, in terms of the respective balance of structural or personal factors in triggering episodes of homelessness, the duration of these episodes, and the implications of these divergent results for framing public policy responses. Over thirty years ago, Shinn and Weitzman (1990), when reviewing the research output on homelessness in the United States, observed that the existing research 'paid extensive attention to the characteristics of people who are homeless, especially in regard to their health and mental health status' (p.1). This extensive focus on the characteristics of those experiencing homelessness, they argued, risked 'diverting attention from the underlying causes and reinforcing stereotypes about the population group' (Shinn and Weitzman, 1990, p.2). Giving the example of mental illness, they argued that much of the existing research on homelessness and mental illness 'exaggerate the role of mental illness as a cause of homelessness' (Shinn and Weitzman, 1990, p.2; see also Shlay and Rossi, 1992, p.138 for a similar conclusion).

A number of years later, when Snow et al. (1994) published a review of contemporary research on homelessness in the US, they reiterated the conclusions of Shinn and Weitzman (1990) in observing that the bulk of the research literature portrayed the majority of those experiencing homelessness, particularly those literally homeless on the streets, as 'drunk, stoned, crazy or sick' (p.462). This portrayal of those experiencing homelessness was, they argued, distorted and flawed, resulting from the use of research methodologies and instruments that were unable to capture the dynamics and context of the experience of homelessness. Shinn (1992) conveyed a similar and sustained critique of the 'large and relentlessly negative literature on rates of substance abuse and psychiatric impairment among homeless people' (p.2). Cross-sectional research methods, which uncritically used the instruments of psychiatric diagnosis, neglect to contextualise the experience of homelessness and medicalise the social, were particularly singled out by Snow and colleagues as contributing to 'a truncated, decontextualized, and over pathologized picture of the homeless' (1994, p.468) (see also Phelan and Link, 1999). Some of this research was also used by advocates as a way of framing homelessness, 'as a way a garnering support for those experiencing homelessness as victimized by disease and dysfunction rather than the result of bad individual choices' (Lyon-Callo, 2000, p.330).

This critique of existing research by Snow and colleagues emerged from their ethnographic research on those experiencing literal homelessness in Austin, Texas, where the behaviour and actions of their informants did not tally with the results from the cross-sectional research. Rather than being struck by the pathology of those on the streets, they were struck by their 'normalcy' and that the disabilities observed were disabling contexts and situations rather than traits of the individuals encountered (Snow and Anderson, 1993, pp.314-315). Similar conclusions also were noted by other ethnographers such as Hopper (2003) and Rosenthal (1991). Thus, the research methods utilised to enumerate, characterise, and describe those experiencing homelessness vary significantly by method and design, with for example ethnographic methods providing a very different description of those experiencing homelessness than did cross-sectional methods.

In this paper, we summarise some of the recent developments in researching those experiencing homelessness, particularly the linking of administrative and survey data and the development of RCTS in evaluating interventions designed to assist those experiencing both long term forms of homelessness and families experiencing homelessness. Despite these methodological advances and innovations, cross-sectional research methods continue to be widely used, despite the long-standing identification of the limitations of this methodology for understanding homelessness, in that it was capturing the 'demographics and disabilities' of the minority 'long term homeless' population, but failing to adequately capture the majority of people who experienced homelessness over a period of time. We then explore some of the recent social science research on the links between the experience of homelessness and mental ill-health and substance misuse, which broadly concludes that the majority of people experiencing homelessness do not experience mental ill-health or substance misuse problems. We then provide case studies of medical research from Ireland, Germany, the United Kingdom, and Slovenia and argue that, based on these case studies, such research continues to distort our understanding of homelessness and may inadvertently lead to ineffective policy responses that fail to resolve homelessness. In this next section we explore a number of recent trends in research on those experiencing homelessness and the implications of this for public policy.

Homelessness Research Strands and Policy Making

Snow et al. (2007) identified three key strands of contemporary homelessness research in the US. An ethnographic strand that explored, in the main, the experiences of the literally homeless and their 'strategies of survival'; a strand of macro-level multivariate research that aimed to understand the relationship between, for example, housing affordability, poverty, and rates of homelessness; and a strand,

largely cross-sectional and quantitative, that surveyed the characteristics of those experiencing homelessness. Over a decade ago, in a review of evidence on home-lessness in Europe, Busch-Geertsema et al. (2010, p.15) noted that

> Although a clearer consensus has developed over the past two decades amongst researchers on the causes of homelessness, this consensus is more at the ideological than at the empirical level. In other words, some of the new hypotheses about the nature of homelessness causation are difficult to entirely prove because there is still an absence of robust data on people experiencing homelessness. Considerable difficulties remain in demonstrating empirically how the confluence of adverse structural and individual factors may 'trigger' homelessness and how intervening variables, from welfare regimes to housing policy to policing policy to addiction treatment policy, contribute to patterns of homelessness across the EU.

There are also distinct research traditions in researching homelessness between North America and the UK, for example, where the bulk of research on homeless-ness published in English originates. Fitzpatrick and Christian (2006) noted the dominance of increasingly sophisticated quantitative research methodologies in the US, with qualitative methodologies dominating in the UK, with a broadly similar picture in other European countries (Edgar et al., 2003). In disciplinary terms, community psychology has had a particularly significant contribution to homeless-ness research in North America (Hanson and Toro, 2020), as has economics (O'Flaherty, 2019), and sociological and medical perspectives (Culhane et al., 2020). But this is less so in Europe, with the disciplines of housing studies and social policy to the fore (Christian, 2003; Tosi, 2010), although, in recent years, community psychologists have been prominent in evaluating Housing First projects in Europe (see for example, Aubry et al., 2018).

Developments in research methodologies and design, disciplinary synergies, and new data sources are allowing for greater clarity and nuance in understanding the 'triggers' that result in some households experiencing homelessness. In addition to research strands noted above, we can also add a burgeoning qualitative strand in which a 'pathways' approach to analysing trajectories through homelessness has been particularly influential (Clapham, 2003; O'Sullivan, 2008, Wagner, 2018). The use of Randomized Controlled Trials (RCTs), particularly in the evaluation of the efficacy of Housing First approaches (Goering et al., 2011), but also family home-lessness (Gubits et al., 2018), is another notable development. As is a strand of research that has made an enormously productive use of utilising linked longitu-dinal administrative data from homeless and other social, health, and criminal justice services (Culhane, 2016; Benjaminsen, 2016), and combining data sets from various household surveys (Bramley and Fitzpatrick, 2018). Linking longitudinal

panel surveys with administrative data, in the case of Journeys Home in Australia (Wooden et al., 2012; Herault and Johnson, 2016), has 'answered old questions that had never been approached satisfactorily before, [and] raised some new questions that had been impossible to think about before' (O'Flaherty, 2019, p.4). Finally, both comparative cross-national and national studies of policy responses to those experiencing homeless have demonstrated that both preventing households experiencing homelessness and exiting those households currently experiencing homelessness is possible when public policy focuses on the provision of secure housing rather than shelters as the primary response (Allen et al., 2020; Aubry et al., 2021; O'Regan et al, 2021; Shinn and Khadduri, 2020; Stephens et al., 2010).

A number of authors have critiqued social science research on homelessness suggested that research on homelessness should be 'unruly', unsettling 'the objectifying lens so often applied to those whom academics take as their research objects' (Farrugia and Gerrard, 2016, p.280); it should be disruptive, bold, and innovative (Lancione, 2016, p.164), and criticized for 'asking only limited questions' around the management of homelessness (Willse, 2015, p.182). Others have argued Pleace (2016a) that the evidence base in respect of understanding homelessness 'has undergone radical change in the last 25 years' (p.26) and this research base has had positive impact on policy. Equally, O'Flaherty (2019, p.23), while noting the significant gaps in our knowledge on various aspects of homelessness, concludes in his review of the economic literature on homelessness 'we have learned a lot.'

Methodological advances in researching the experience and, more significantly, the dynamics of homelessness, has led in a number of cases to evidence-based policy shifts in responding to homelessness, particularly in the case of adopting Housing First (Nelson et al., 2021; O'Sullivan et al., 2021). However, not to the degree that might be expected given the methodological advances described above, and in the case of the findings from Journeys Home data in Australia, O'Flaherty (2019, p.5) caustically notes that 'policy-makers do not seem to be clamouring to acquire this information and be guided by it.' Parsell (2017, p.134) convincingly argues that households continue to experience homelessness 'not because we lack the scientific knowledge but rather because of our values and the political decisions we make.'

In brief, we argue that over the past 20 years or so, our understanding of the characteristics of those experiencing homelessness and solutions to homelessness has been shaped by increasingly sophisticated methodological approaches and designs. In particular, qualitive and ethnographic work that has provided valuable contextualisation and the use of longitudinal administrative and survey data, in addition to randomised control trials, has been used to more fully understand entries to and exits from homelessness.

Our critique in this paper focuses on research on 'homelessness' that remains grounded in cross-sectional research designs. Such approaches are framed by images of homelessness as an issue that primarily involves street-dwelling, lone men presenting with severe mental illness and substance use problems. We argue that these working assumptions on how homelessness is *understood* (Pleace, 2016a) influence how interventions among people experiencing homelessness are defined, operationalised, and evaluated. The ways in which homelessness is often counted, both in terms of where it is looked for and the expectation of what will be found, i.e., the validity of methods is not questioned because the results correspond with a predefined image of what 'homelessness' is, also influence these policies.

Lessons Learned: Time, Dynamics, Place, Definition and Policy

Point-prevalence or point-in time surveys of those experiencing homelessness are widely used to determine the number of people experiencing homelessness as well as their characteristics. As Shinn and Khadduri (2020) acknowledge, this method can be useful for monitoring trends and identifying service needs, but minimises the scale of homelessness, and period-prevalence surveys are required to more accurately estimate the number of people who experience homelessness over a time period. Shinn and Khadduri argue that *time-frames* (2020, pp.26-27) are also important in researching those who experience homelessness as the numbers who experience homelessness *and* their characteristics will differ significantly depending on the time-frame used. Shorter time-frames largely capture those experiencing long term homelessness with longer time-frames capturing the significantly larger number of people who enter and exit homelessness each year. For example, Link et al. (1994) found that the life-time prevalence of homelessness was 7.4% in comparison to 3.1% over a five-year period. A recent study utilising a similar methodology in eight European Countries found a lifetime prevalence of nearly 5%, albeit with significant variations by country, with a 5-year prevalence of just under 2% (Taylor et al., 2019).

Time-frames are also important in understanding both the experience of homelessness and pathways to and exits from homelessness. Further, they matter in for example, how levels of psychological distress vary whether you are entering, experiencing, or exiting homelessness, whether you are male or female, as well as in enumerating homelessness (Johnson and Scutella, 2018). Homelessness is a dynamic process and capturing the experience of homelessness at a point in time does not reveal the fluidity of the experience of homelessness and that the majority who experience a spell in an emergency shelter, for example, will exit to housing and stay housed (Lee et al., 2021). This was demonstrated when an increasing number of researchers from the 1990s onward, initially almost exclusively in North America, and

subsequently in a number of European countries and Australia, utilising longitudinal research methods were showing very different patterns of homelessness than that found in cross-sectional research, with profound implications for policy (Dworsky and Piliavin, 2000; Kuhn and Culhane, 1998; Klodawsky et al., 2007; Shinn, 1997). The importance of subsidised housing, poverty, and other structural factors in contributing to homelessness rather than individual level dysfunctions came to the fore, with 'residential instability' rather than prolonged experiences of homelessness the typical pattern observed (Sosin et al., 1990, p.171).

Where research on those experiencing homelessness takes place also matters. Research that surveys only those experiencing street homelessness or those using designated services and shelters for the 'homeless', will influence how we think about and respond to homelessness. Focusing on these places only will fail to adequately capture, for example, women's experience of homelessness (O'Sullivan, 2016; Pleace, 2016b, Bretherton and Mayock, 2021), and those who are experiencing transitional forms of homelessness. Cloke et al. (2001) argue that a pre-occupation with measuring people experiencing street homelessness in England has resulted in the 'concept, image and number of rough sleepers which has been used as the popular defining representation of homelessness' (p.260), and as a consequence of this focus on people experiencing street homelessness, it 'serves to distort popular appreciations of the scale, profile and location of homelessness in the UK. (p.260)' When the focus of research shifts beyond people experiencing street homelessness and/or in emergency accommodation, women for example, appear in greater numbers. In addition, there are limitations to 'utilisation-based' sources as those that do not utilise services will not be included (Culhane et al., 2020). Based on data from Philadelphia, including those experiencing homelessness but not utilising services would increase not only the size of the population experiencing homelessness, but also alter the race and disability profile of those experiencing homelessness as the non-users were more likely to be white and had lower levels of disability (Metraux et al., 2016).

Also important are the *questions we ask* in doing research. For example, administrative in-take data in Dublin on the 'reasons' why families required emergency accommodated simply asked about their last stable home. Just over 40% cited 'family circumstances' and 50% cited the housing market (Dublin Region Homeless Executive, 2019). However, in a separate piece of work, when asked about their last four accommodations rather than just their last, the role of the housing market, particularly terminations of tenancy or rent increases in the private rented sector, became more pronounced and exiting the family home due to inter-personal difficulties was often the final stage in a process of residential dislocations, primarily in the private rented housing market (Gambi and Sheridan, 2020).

Understanding family homelessness as arising from dysfunctional families would suggest a set of policy responses very different from understanding family home-lessness as resulting from the dysfunctions of the housing market. Because the perception was that family homelessness was a consequence of family dysfunc-tion, the policy response was the establishment of congregate transitional accom-modation units, known as Family Hubs in late 2016, and by 2020 there were over 30 such facilities across the country at a projected revenue cost of over €25m for 2020 (O'Sullivan, 2020). The development of these Hubs was not underpinned by any evidence as to their efficacy and the research evidence is clear that both long and short term housing subsidies are considerably less costly than emergency accommodation or transitional congregate facilities for families, while also offering substantial additional benefits across a range of psycho-social domains, particu-larly for the children (O'Sullivan, 2017; Gubits et al., 2018). A similar response to family homelessness was evident from the 1990s in the US where it was assumed that mothers with children experiencing homelessness required service intensive shelter facilities to prepare them for housing due to their elevated levels of mental distress and depression. This was despite research strongly arguing that 'homeless mothers are an unexceptional subset of impoverished mothers and that there are no systematic psychological differences that predispose them to homelessness' (Bogard et al., 1999, p.54; see also Gerstal, 1996) and that homelessness was more likely to cause depression rather than depression causing homelessness.

Furthermore, *scale matters*. For example, by recent estimates, England, which has a total population of some 56 million, has measured its homeless population at any one point (in pre-pandemic circumstances) at nearly 300 000 (Shelter, 2019; Fitzpatrick et al., 2019). Much of this homelessness was among families, often led by lone women parents in which rates of mental illness do not exceed those found in the general population. By contrast, some 385 000 people had a psychotic disorder (severe mental illness, 0.7% of the population), 2.97 million people (5.4%) report suicidal thoughts and acts of self-harm, and around 2% of adults are screened as having bi-polar disorder (around 1.1 million people). When surveyed, one in six adults in England report 'depression or anxiety' over the course of the last week (Baker, 2020). Beyond evidence that mental health problems may sometimes develop after homelessness, indeed in response to homelessness, the idea that mental health problems are a causal factor, or a 'characteristic' that defines homelessness, falls over very quickly in this context. Rather than drawing an association from the prevalence of severe mental illness derived from oversam-pling people experiencing homelessness for sustained periods, medical researchers might instead ask why such a *small* proportion of people with a mental health problem experience homelessness.

Finally, who we *define* as experiencing homelessness matters. The work of Link and colleagues noted above has shown that both 5 year and life-time prevalence of homelessness increases significantly if you include those in insecure accommodation and involuntarily doubling up, rather than simply those experiencing street and emergency shelter forms of homelessness. Definitions of homelessness also shape how we understand homelessness, with broad definitions finding strong evidence for structural causes of homelessness, with more narrow definitions noting the dysfunctions of the individuals experiencing this relatively rare form of homelessness (Pleace and Hermans, 2020). A striking feature of the bulk of research on homelessness over the past 50 years is the degree to which the research has focused on these relatively rare experiences of homelessness. Analyses of time-series data on shelter admissions in New York and Philadelphia by Kuhn and Culhane (1998) showed a clear pattern whereby approximately 80% of shelter users were transitional users, in that they used shelters for very short periods of time or a single episode and did not return to homelessness. A further 10% were episodic users of shelters, and the remaining 10% were termed long term users of shelter services.

The pattern of shelter use first identified by Kuhn and Culhane (1998) has been replicated in similar analyses of longitudinal administrative data in a number of other cities and countries of the Global North, albeit with some significant differences in the extent of homelessness and the characteristics of those in each cluster in different welfare regimes. For example, Benjaminsen and Andrade (2015) found support in the case of Denmark for the thesis first articulated by Fitzpatrick (1998; see also Stephens and Fitzpatrick, 2007) that in generous and comprehensive welfare regimes, the number of people experiencing homelessness will be low, but the majority will have complex needs, whereas in miserly and rationing regimes, the numbers experiencing homelessness will be high, but only a minority will have complex needs. Equating those experiencing long-term or entrenched forms of homelessness' with 'homelessness' has distorted how policymakers, politicians, and the public understand and respond to homelessness, and this distortion has resulted in policies that fail to address the dynamics and types of homelessness.

In brief, it is clear that there are a variety of experiences of homelessness rather than a singular experience, but research that primarily researched those in emergency shelters or literally homeless, and did so at a point-in-time, neglected the temporal dimension of the experience of homelessness. The dynamics of homelessness have also been underestimated, with the majority of people who experience homelessness exiting and not returning to homelessness, however broadly or narrowly homelessness is defined. In part, this static, reductionist, individualised understanding of homelessness shaped public policy responses. This is seen in the growth of emergency shelters for both families and adult only households in the majority of the countries of the Global North from the 1980s onwards.

Mental Health, Problematic Substance Use and Homelessness

Public opinion supports a view that homelessness – usually understood as literal homelessness – is the preserve of largely single male adults, often with mental ill-health and/or alcohol/substance misuse problems (Batterham, 2020). However, as discussed above, this view is at odds with the social science research on homelessness in the Global North, but it does resonate with much of the medical research on the characteristics of those who experience homelessness. Snow et al. (1986, p.408) noted in their review that 'it would appear that the modal type among the homeless today is an interactionally incompetent, conversationally incoherent, occasionally menacing, and institutionally-dependent "crazy."' They argue that '[s]uch a root image or characterization is not merely a media creation. It has substantial footing in a spate of research conducted primarily by psychiatrically-oriented investigators.' When corrected for the 'diagnostic biases' in much of this research, they argue that 'the modal type among the homeless is a psychiatrically non-impaired individual trapped in a cycle of low-paying, dead-end jobs which fail to provide the financial wherewithal to get off and stay off the streets' (Snow et al. 1986, p.421).

This strand of medical research remains prevalent. In a review of studies exploring the 'prevalence of mental disorders amongst the homeless in Western Europe', (Fazel et al., 2008, p.1670) concluded that '[h]omeless people in Western countries are substantially more likely to have alcohol and drug dependence than the age- matched general population in those countries, and the prevalence of psychotic illnesses and personality disorders are higher.' A further review of the health status of people experiencing homelessness in high income countries claimed that '[h]omeless people have higher rates of premature mortality than the rest of the population, especially from suicide and unintentional injuries, and an increased prevalence of a range of infectious diseases, mental disorders, and substance misuse' (Fazel et al., 2014, p.1529). More recently, an evidence review of drug treatment services for people who are homeless and using drugs claimed that people experiencing homelessness 'tend to have worse physical and mental health, and are more likely to report problem substance use, than the general population' (Miler et al., 2021, p.9).

In the case of homelessness and substance misuse, Johnson and Chamberlin (2008) observe that, despite popular opinion regularly citing substance misuse as a cause of homelessness, their detailed large-scale research of two inner city homelessness services in Melbourne showed that only 15% had substance misuse problems prior to entering homelessness services for the first time. This early finding has been validated in Australia by more recent work using the compara-tively, unusually robust, Journeys Home dataset (McVicar et al., 2015; McVicar et al., 2019). O'Flaherty (2019) has noted that both the Journeys Home data and the

North American RCTs confirm that 'because substance misuse for the most part does not cause homelessness, treatment of substance abuse is neither necessary nor sufficient for ending homelessness' (p.5).

Johnson and Chamberlain (2011) also explored the relationship between mental illness and homelessness using the same dataset from Melbourne and demonstrate that it is 'inaccurate to claim that most of the homeless are mentally ill, or that mental illness is the primary cause of homelessness' (p.44). As with their research on homelessness and substance misuse, their finding on homelessness and mental illness is confirmed by analyses of the Journeys Home data (Moschion and van Ours, 2020). In the US, research identified the difficulty of distinguishing between the symptoms of mental illness and behaviours that reflected an adaptation to living in public spaces or congregate shelters, thus potentially leading to bias in attributing homelessness to mental ill health due to inadequate diagnostic assessments. Claims of high rates of mental illness among those experiencing homelessness arose from the limitations of the predominantly cross-sectional methodology, and 'confounded the understanding of those who became homeless with those who *remained* homeless' (Montgomery et al., 2013, p.64, author's emphasis). Montgomery et al. (2013) concluded that 'the research supports there being nothing inherent to serious mental illness that leads to homelessness, rather this link is mitigated by the economic difficulties that often accompany living with mental illness in the community' (p.68). More recent analyses from the methodologically robust Australian Journeys home data also supports this analysis with the authors concluding that 'mental health issues are unlikely to be the main cause of homelessness' (Moschion and van Ours, 2020, p.12).

In the next section we explore a number of case studies of research that have proved influential, but due to the methodologies employed, have contributed to distorting our understanding of homelessness.

Ireland

Medical research on homelessness in Ireland, and particularly in Dublin, have stressed the disabilities of those experiencing homelessness. For example, Ni Cheallaigh et al. (2017) state that '[i]n Dublin, homelessness is strongly associated with drug use: up to 70% of homeless individuals report having used illegal drugs with over half reporting injecting drugs.' O'Carroll and Wainwright (2019, p.1) note that '[h]omeless people also have high rates of mental-ill health with high rates of schizophrenia, depression and anxiety. This increased mental illness burden has resulted in higher suicide rates. People experiencing homelessness also have much higher rates of alcohol and substance use disorders than the general population. Irish studies have found similar high rates of addiction, poor physical and mental health.' For Moloney et al. (2021, p.1.) 'it is well documented that homeless people

have greater health needs than the general population, including a higher preva-
lence of severe psychiatric illness with complex needs.' Equally, Glynn et al. (2017)
state that '[i]t is clear, therefore, that a substantial proportion of people who are
homeless in Ireland today have ended up – and remain – in that position because
of ill-health and addiction.'

These stark conclusions and broad consensus that the majority of those experi-
encing homelessness in Dublin are afflicted by various forms of ill-health and
substance misuse arise from four influential studies of shelter users primarily in
Dublin conducted between 1997 and 2013. In these studies, the methodologies
were cross-sectional, questionnaire-based surveys of those residing in emergency
shelters, both private and NGO operated, and those accessing street-based
outreach health services. These studies were conducted in 1997 (Holohan, 1997),
2005 (O'Carroll and O'Reilly, 2008), 2011 (Keogh et al., 2015) and 2013 (O'Reilly et
al., 2015) with sample sizes ranging from 105 to 601. Approximately one-quarter of
those in the 2011 survey were deemed at risk of homelessness rather than living in
emergency accommodation or experiencing literal homelessness, and only the
2005 survey included those accessing street based outreach health services.

O'Reilly et al. (2015), based on their cross-sectional, questionnaire-based survey
of 578 users of various types of temporary and emergency accommodation in
Dublin and Limerick and 23 people experiencing street homelessness in Dublin,
concluded that the 'results show a predominantly male, Irish Roman Catholic
homeless population….Family problems and drugs and alcohol addiction featured
heavily as self-reported reasons for homelessness. Homelessness was often long
term….There was a disproportionate number in the sample who had been in care
as a child' (p.9).

In contrast, research utilising longitudinal administrative data in Dublin showed that
12 734 unique individuals utilised emergency shelters in Dublin between 2012 and
2016 (Waldron et al., 2019). The majority, 9 915 or 78%, were in the transitional
category in that they had short term stays, with 1-2 experiences of staying in
emergency accommodation over this period and 75% having one episode only over
this period; results that align with comparable research in a number of other
countries as noted earlier. Those in the long term cluster accounted for just over
12% of total users over this period. Between 2017 and 2020, a further 12 500 unique
adults entered emergency accommodation in Dublin for the first time. If the pattern
identified between 2012 and 2016 applied between 2017 and 2020, some 22 500
adults are likely to have experienced a transitional stay in emergency accommoda-
tion between 2012 and 2020, in comparison to the 3 000 who are likely to have
experienced a more long term experience use of emergency accommodation.
Those in the long term category are largely those surveyed in the four cross-

sectional reports cited above and based on the characteristics of those in this category from other countries. This considered, the results of the surveys are not particularly surprising.

However, as a consequence of the research design, the majority of adults who experienced a stay in emergency accommodation in Dublin in recent years will not be captured in cross-sectional surveys, and for this group, again based on what we know of characteristics of this category in other liberal welfare regimes, the primary reason for experiencing a stay in emergency accommodation is an inadequate supply of affordable housing coupled with a 'shock' (economic or personal, such as the loss of employment or break up of a relationship).

Thus, homelessness in Dublin *is not strongly* associated with high rates of substance use or mental ill-health. For those experiencing long term forms of homelessness this is more likely to be the case, and hence understanding the needs of this group is crucial to developing an adequate response, but their needs cannot be attributed to all those who experience homelessness. Using longitudinal administrative data rather than cross-sectional data show very different patterns, dynamics, and characteristics of those experiencing homelessness, and the policy consequences that stem for these divergent conclusions are significant. Basing policy responses on the administrative data would, for example, suggest increasing the supply of affordable housing, ensuring people exit emergency accommodation as soon as possible, and not utilise emergency accommodation as an alternative to affordable housing. On the other hand, basing policy on the cross-sectional data would suggest providing enhanced substance misuse treatment services, more extensive mental health services and other treatment interventions, and a graduated services of accommodation services that assist those individuals to manage their addictions and trauma.

Germany

In Germany a large medical study was published in 2017 about mental health problems of people experiencing homelessness called the SEEWOLF study (Bäuml et al., 2017). One of the most prominent results was that 93% of the sample analysed had a diagnosis of mental illness at some point in their entire life and 74% had an acute mental illness in need of treatment during the preceding month. The results were widely distributed even years in advance of the publication of the book through press releases and reports by prominent magazines and newspapers. Main headlines were 'Many roofless people suffer from mental dysfunctions' (Spiegel online, 2014), "Many homeless people are mentally ill" (Ärzteblattt, July 2014), etc.

Looking in more detail at the study (once it was published), the sample focused exclusively on single people experiencing homelessness who used particular hostels for specific groups of single individuals experiencing homelessness in Munich.

Families experiencing were completely excluded from the sample as were other groups of people experiencing homelessness (including those experiencing street homelessness). About half of the whole sample was recruited from institutions where it is a requisite to have a serious mental health problem in order to get access to these institutions. The average duration of homelessness in this sample was as high as 61.3 months, i.e., more than five years. Thus, the results of this very influential study arrive from a highly selective sample which is in no way representative of 'people experiencing homelessness', neither in Munich nor in Germany. However, it is quoted repeatedly with reference to the total number of persons estimated as homeless in Germany (for further details see Busch-Geertsema, 2018).

Recommendations of the study called for more enforced treatment and for a massive 'transfer' of the large majority of people experiencing homelessness into 'institutionalised psychiatry'. Housing First was not presented as an option despite a large international literature review and the fact that Housing First has been developed predominantly for mentally ill people experiencing homelessness.

It is probable that in Germany people with a mental illness, especially if they try to avoid medical treatment, have a higher risk of becoming homeless than the general population. But it is also important to keep in mind that most mentally ill people are not homeless and life in regular, permanent housing. While we still lack reliable studies on the overall prevalence of mental illness among all people experiencing homelessness in Germany, it seems reasonable to assume that the proportions are much smaller than that found in the Munich study.

UK

The UK saw a shift in the administrative and political perception of homelessness as the experience of homelessness among families started to be interpreted as systemic causation. From the 1960s onwards, homelessness was increasingly seen as being generated by inequality, housing market failure, and weaknesses in social protection systems (Greve et al., 1971). The collection of data from the English 1977 homelessness legislation, which focused on family homelessness and 'vulnerable' adults, showed a population that matched this picture. Homelessness had primarily social and economic causation among people whose chief characteristic was poverty and precarity.

It remains the case, for example, that a significant amount of UK homelessness is triggered by domestic abuse. What is called 'family homelessness' is predominantly lone women parents who have often experienced domestic abuse and who are characterised by poverty and precarity. Homelessness, according to administrative systems, is also quite frequently triggered by an eviction from a private

rented sector tenancy. These numbers are much higher than for people whose homelessness is associated with mental illness and dwarf the numbers experiencing street homelessness (Fitzpatrick et al., 2019).

However, much of the British medical research on homelessness has followed the global trend to use what is essentially a cultural or mass media 'definition' of homelessness. This is within a broader context in which portrayals of homelessness have been driven by successive governments wishing to emphasise individual pathology in causation (Anderson, 1993). Cross-sectional studies therefore often report astronomical levels of substance misuse problems, mental, and physical illness.

Again, 'homelessness' means a static population of people experiencing street homelessness and shelter users who can be reliably sampled using cross-sectional methods. For example, a paper from 2012 notes 'rates of traumatic brain injury are much higher among the homeless population than in the general population and that sustaining a traumatic brain injury may be a risk factor for homelessness' (Oddy et al., 2012, p.1058). The study was based on a small, cross-sectional sample of long term and repeatedly homeless lone adults; leading to the reporting of brain injury as present in 48% of homeless adults. Another paper from 2017 talks of 'in the presence of physiological stresses arising from exposure *to harsh environmental conditions*, the absence of a nutritionally balanced diet is likely to have a detrimental impact on the health of a homeless individual' (Fallaize et al., 2017, p.707, author's emphasis).

UK health and homelessness literature often works on the basis that people experiencing homelessness live on the streets and homelessness services. Families who are homeless are often placed in temporary accommodation, they are not in homelessness services or on the street, and women who are homeless due to domestic abuse and living in refuges are not counted (Bretherton, 2017). At the time of writing, the UK has had relative success in keeping levels of COVID-19 infection down among people experiencing homelessness, a success reported in the following terms by medical researchers:

> In this first wave of SARS-CoV-2 infections in England, we estimated that the preventive measures imposed might have avoided 21 092 infections (19 777–22 147), 266 deaths (226–301), 1 164 hospital admissions (1 079–1 254), and 338 ICU admissions (305–374) among the homeless population. (Lewer et al., 2020, p.1183)

The population being referred to in this study is referred to as '46 565 individuals experiencing homelessness' at one point there is a note that there are different types of homelessness, but note the language in the quote above, 'among *the* homeless population' (Lewer et al., 2020, author's emphasis). In the third quarter of 2020,

government statistics recorded 93 490 statutorily homeless households placed in temporary accommodation by local authorities in England, containing 59 360 adults and 120 570 children. This population, not living on the streets or within homelessness services that were designed for lone homeless adults, were simply outside the operating assumption, the *image* of what the homeless population was.[1]

Slovenia

Slovenia presents a case where cross-sectional research methods have mainly been used to study homelessness, though still rather scarcely. One of the most important studies is that of Dekleva and Razpotnika (2007) that focused only on people experiencing homelessness using (selected) services for the homeless in Ljubljana; they used a narrow definition of homelessness, i.e. those experiencing street homelessness or in shelters and basements and had no home of their own. The small sample of 107 people also limits detailed analysis. Their results showed that they included a high proportion of very long term people experiencing homelessness, 21% of the sample was homeless for more than 10 years, with more than half being homeless more than two years. Additionally, 85% of the sample were men and a high share of interviewees had occasionally or regularly used alcohol (61%) and drugs (40%).

A similar approach to the one described above was taken in a study of the health and access to health care of people experiencing homelessness (Razpotnik and Dekleva 2009). The study included 122 people from various Slovene cities, and selection was a non-random sample of self-defined people experiencing homelessness – i.e. those sleeping outside, in basements, shelters, and other accommodations for homeless, and who had no place to go or were threatened by eviction. Similarly, as in the previous survey, 84% were men. Among respondents, 34% had alcohol use disorder, 26% substance use disorder, several listed health problems, and 16% also reported substance overdose.

These studies have focused on a specific subgroup – males that have experienced long term homelessness and reconfirm the problems of cross-sectional studies and focused samples based on users of shelters and those experiencing street homelessness for understanding homelessness. It reinforces the narrow view of the homeless population, overemphasising their health issues, problematic alcohol and substance use, as well as portraying the population as mainly male. However, in a research vacuum that exists in Slovenia, we might argue that such research is important for bringing the problem into policy attention and improving national understanding of the issue. However, it also reinforces the placement of the issue

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[1]   Source: MHCLG (2021) https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

into the social problems arena and not housing problems. It is therefore not surprising that homelessness in Slovenia is mentioned mainly within social protection and social inclusion policy documents, but has almost no presence in housing policy (see Filipovič Hrast, 2019).

A broader study on homelessness done a decade ago (Dekleva et al., 2010) encompassed homelessness in a more comprehensive way and followed the ETHOS typology. Due to the lack of original data, and the limited existing official data, only some information on specific subcategories was available – such as number of users of homeless services, users of women's shelters, and people with specific housing problems. However, no data was available on the demographic profile of these groups, so no comprehensive additional knowledge about the characteristics of this population was gathered.

The research on homelessness enables development of policy measures as well as enables placement of the issue on the public as well as political agenda (see Lux, 2014; Hermans, 2017; Benjaminsen and Knutagård, 2016). The lack of research into homelessness has been identified as an important drawback in the development of more comprehensive policies in this area in Slovenia (see Filipovič Hrast, 2019). However, as stated above, it is important to research not only specific population groups and users of services in cross-sectional studies, as this distorts the issue and reconfirms the established narrower approach for addressing it.

Conclusion

In conclusion, within the social sciences, consistent evidence demonstrates that the majority of those experiencing homelessness experience short term episodes, and that only a minority experience entrenched or long term homelessness. Those with complex needs can be successfully housed without having to be 'prepared for housing', rather what is required is support *in* housing to maintain their tenancy. Cross-sectional research, particularly in the health domain, continues to be used extensively, contributing to some of the enduring myths of contemporary homelessness, particularly that those experiencing homelessness have elevated rates of mental ill-health and substance misuse than the general public. In turn, high rates of mental ill-health and substance misuse also explain *why* people are experiencing homelessness, thus contributing to the understanding of the enormous complexity of responding effectively to their needs and explaining the stubbornly high numbers of people experiencing homelessness, despite the best efforts of government and civil society.

A focus on both emergency accommodation and literal homelessness, allied to the inability of cross-sectional research to uncover the dynamics of homelessness, resulted in a misleading picture of those experiencing homelessness as being largely single males with a range of disabilities, rather than a relatively heterogeneous population in terms of gender, disabilities, and duration of homelessness. It failed to grasp that the majority of people who experienced homelessness exited from homelessness relatively quickly, requiring little social support in doing so, and did not return to homelessness.

How we research homelessness has important implications for public policy. As noted from the case studies and the wider literature, the idea that homelessness is caused by mental-ill health and or substance misuse is not untrue, but only applies to a minority of those experiencing homelessness rather than the majority as suggested by much of the cross-sectional research. Even for the minority of those experiencing homelessness who do have mental ill-health and substance misuse problems, the evidence is that resolving their homelessness does not require treatment prior to housing, rather it is best resolved in a home of their own.

Despite the significant methodological and theoretical advances in understanding the dimensions and dynamics of homelessness in Europe, and the inadequacy of cross-sectional research methods to understand homelessness, this method of researching homelessness continues to be extensively used in medical research in particular, resulting in significant distortions. The significance of these distortions for public policy should not be underestimated. If public policies responding to homelessness are to be evidence based, the robustness of the methodologies underpinning the evidence is crucial, and flawed methodologies are likely to generate flawed data, and may translate into flawed policies.

Acknowledgements

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